1 12

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02931 02923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 5 Wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paw Paw
d. STREET ADDRESS: Route #31
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: G. — Last: Arnica

4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/10/13

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Raygold Mfg. Co.

10b. KIND OF BUSINESS OR INDUSTRY: Kitchen Cabinets

11. BIRTHPLACE (County & State, or foreign country): Paw Paw, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert F. Arnica

14. MOTHER'S MAIDEN NAME: Annie M. Leach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-10-9683

17. INFORMANT: John Arnica, Address: Paw Paw, W. Va. — patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fibrinous Pericarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute Glomerulonephritis, Rt. — 5 weeks
DUE TO (c):

590X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Previous Nephrectomy, Traumatic at age 15

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MARCH 9, 1967 to MARCH 14, 1967, that (I) (we) last saw the deceased alive on MARCH 13 1967, and that death occurred at 10:20 A M, from the causes and on the date stated above.

22a. SIGNATURE: Richard Schindler M.D. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-14-67

22c. PHYSICIAN'S NAME (Type): Dr. Richard Schindler

22d. ADDRESS: 69 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/17/67

23c. NAME OF CEMETERY OR CREMATORY: Camp Hill Cem.

23d. LOCATION (City, town or county) (State): Paw Paw, W. Va.

24. FUNERAL DIRECTOR: Johnson Funeral Homes

ADDRESS: Berkeley Spgs. W. Va.

25a. REC'D BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11 & 14, Film C388 5/5/67 kk

02932

CERTIFICATE OF DEATH

02924

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing 01-1
d. STREET ADDRESS: Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: E. — Last: Baumann

4. DATE OF DEATH: Month: March — Day: 28 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/19/1900
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator of Restaurant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Woodland Klondike, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Kaefer
14. MOTHER'S MAIDEN NAME: Eve B. Lehr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anthony Keafer "Brother" — Address: Rt 1. Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Lobar pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
490X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/24, 1967 to 3/28, 1967 that (I) (we) last saw the deceased alive on 3/28 1967, and that death occurred at 8:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/28/67
22c. PHYSICIAN'S NAME (Type): John B. Davis, M.D.
22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/67
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Lonaconing A. Md

24. FUNERAL DIRECTOR: George Eichhorn
ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: MAR 31 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yuga

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02933 02925

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
d. STREET ADDRESS: R.D.#1, Gramleck Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: M. — Last: Beckman
4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/93 Apr. 5 1893
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & State, or foreign country): Swanton, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John A. Beckman
14. MOTHER'S MAIDEN NAME: Mary Mc Fadden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes II (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: patient's chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	1 day
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart Disease	2 yrs.
DUE TO (c)	Coronary Insufficiency	2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to March 14, 1967, that (I) (we) last saw the deceased alive on March 14, 1967, and that death occurred at 9.55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James F. Hallinan M.D. — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-17-67
22c. PHYSICIAN'S NAME (Type): Dr. James P. Hallinan
22d. ADDRESS: 140 Bedford St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR: MAR 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02934

CERTIFICATE OF DEATH

02926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 27 hrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 314 BROADWAY
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DONA [illegible] Middle: M Last: BLANK

4. DATE OF DEATH: Month: 3/6/67 Day: Year: 19

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/12/14

9. AGE (In years last birthday): 52 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Parsons, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Freeman Kellar

14. MOTHER'S MAIDEN NAME: Effie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: PT'S CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Failure	2 days
DUE TO (b)	Bronchopneumonia	5days
DUE TO (c)	Emphysema acute, bilateral	10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chronic bronchitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 5, 1967 to March 6, 1967, that (I) (we) last saw the deceased alive on March 6, 1967, and that death occurred at 5:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Louis T. Baccigalupi M.D.

M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-7-67

22c. PHYSICIAN'S NAME (Type): DR. HALLINAN - James P. Hallinan M. D.

22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli,

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR AI5 (4) 2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02935 02927

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grantsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda Middle: Lee Last: Blocher

4. DATE OF DEATH: Month: 3 Day: 23 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/09/50

9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Blocher

14. MOTHER'S MAIDEN NAME: Patsy Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: patient's chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 mon

7054
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Disseminated Lupis Erythematosis — 3yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-21, 1967, to 3-23, 1967, that (I) (we) last saw the deceased alive on 3-23 1967, and that death occurred at 11 P M, from the causes and on the date stated above.

22a. SIGNATURE: W C Spiggle M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-24-67

22c. PHYSICIAN'S NAME (Type): Dr. Wayne Spiggle

22d. ADDRESS: 126 N. Smallwood, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/27/67

23c. NAME OF CEMETERY OR CREMATORY: Grantsville Cemetery

23d. LOCATION (City, town or county) (State): Grantsville Garrett, Md.

24. FUNERAL DIRECTOR: Don Newman ADDRESS: Grantsville, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02936

CERTIFICATE OF DEATH

02928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1050 National Highway

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
   d. STREET ADDRESS: 1050 National Highway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Ruth — Last: Boch

4. DATE OF DEATH: Month: March — Day: 11 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 19, 1894

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerome J. Burkey

14. MOTHER'S MAIDEN NAME: Mary C. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George A. Boch — Address: La Vale, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	1 day
DUE TO (b)	Arteriosclerotic Heart Disease	5 yrs.
DUE TO (c)	Diabetes mellitus	5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 19 67, to Mar. 11, 19 67, that (I) (we) last saw the deceased alive on March 11, 19 67, and that death occurred at 8. A.M. from the causes and on the date stated above.

22a. SIGNATURE: James F. Sullivan M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-15-67

22c. PHYSICIAN'S NAME (Type): James F. Sullivan M. D.

22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/14/67

23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem.

23d. LOCATION (City, town or county) (State): Cumberland Md

24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02937 02929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL 900 SEATON DRIVE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 608 N. MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA Middle MABEL Last BRADLEY
4. DATE OF DEATH: Month MARCH Day 30 Year 19 67
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 19, 1898
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months 11 Days 20 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWF.
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & State, or foreign country): GREAT CAPON WEST VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH SNYDER
14. MOTHER'S MAIDEN NAME: ALICE ~~XX~~ TRUE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-1338
17. INFORMANT Address: HOSPITAL CHART-SACRED HEART HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — 5 YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC BRONCHITIS. UREMIA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2 - 16, 19 65, to 3 - 30, 19 67, that (I) (we) last saw the deceased alive on 3-30, 19 67, and that death occurred at 2 P M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-30-67
22c. PHYSICIAN'S NAME (Type): RALPH W. BALLIN M.D.
22d. ADDRESS: 62 GREENE ST. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-1-67
23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: APR 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
2DM 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02930

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 52 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: Route 4, Oldtown Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Belle — Last: Brake

4. DATE OF DEATH: Month: March — Day: 2 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1892

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months: ____ Days: ____
IF UNDER 24 HRS: Hours: ____ Min: ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Elkins, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Moore

14. MOTHER'S MAIDEN NAME: Emma J. Ice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Daughter
Mrs. Marie E. McDonald, Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS — ----

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): ____

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: March 2, 1967
Cumberland, M.D

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 4, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. RECD BY REGISTRAR — DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02939

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02931

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 701 Louisiana Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Robert — Middle: Earl — Last: Brannon

4 DATE OF DEATH: Month: March — Day: 21 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Nov. 25, 1896

9 AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Textile

11 BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Brannon

14. MOTHER'S MAIDEN NAME: Elizabeth Farrell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give war or dates of service): War I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Eugene Brannon, Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Atelectasis of lungs, bilateral — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Pulmonary Embolism — Days
DUE TO
(c): Multiple Injuries — 70 Days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of Auto involved in accident

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: March 21, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 27, 1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Savage Cemetery
23d LOCATION (City or Town) (County) (State): Mt. Savage, Md. Allegany

24 FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a REC'D BY REGISTRAR: MAR 27 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office when with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02940

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02932

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 40 Days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: West Virginia
b. COUNTY: Hanpshire
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paw Paw

3 NAME OF DECEASED (Type or print): First: Osa — Middle: — Last: Brelsford

4 DATE OF DEATH: Month: March — Day: 12 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4-2-84

9 AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b KIND OF BUSINESS OR INDUSTRY: Farming

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Benjamin Brelsford

14 MOTHER'S MAIDEN NAME: Sallie Moreland

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: 220-05-6351A

17 INFORMANT — Address: Memorial Hospital-Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Days
9040
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Fracture of Neck of Left Femur — 40 Days
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Fell at Home

20c TIME OF INJURY Month Day Year: Hour 9:00 pm Feb. 5 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.): Home

20f (City or town) (County) (State): Paw Paw Hamps. W.Va.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Benedict Skitarelic (M.D.) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: March 12, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 3/14/1967

23c NAME OF CEMETERY OR CREMATORY: Mt. Union Cem.

23d LOCATION (City or Town) (County) (State): Slanesville, W. Va.

24 FUNERAL DIRECTOR: Johnson Funeral Homes, Berkeley Spgs.

ADDRESS

25a REC'D BY REGISTRAR DATE: MAR 14 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film 63-73/30/67 ps

CERTIFICATE OF DEATH

02941 — 02933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c. LENGTH OF STAY IN 1b: 3 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: 451 WAVERLY TERRACE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First GEORGE — Middle E. — Last BROWN	4. DATE OF DEATH: Month MARCH — Day 22 — Year 19 67
5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 12-14-01/ 02 — 9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plummer Helper — 10b. KIND OF BUSINESS OR INDUSTRY: Individual — 11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA — 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: ROBERT BROWN — 14. MOTHER'S MAIDEN NAME: WHITE, ABBIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO: 217-10-7230 — 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	2 days
DUE TO (b)	Acute Cardiac Decompensation	3 days
DUE TO (c)	Bilateral Lobar Pneumonia	4 days

4344

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Mar 20, 19 2:20 P.M. Mar. 22 67, and that (I) (we) last saw the deceased alive on Mar. 22 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 3/23/67	
22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT	22d. ADDRESS: CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Mar.25,1967	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem. — 23d. LOCATION (City or Town) (County) (State): Cumberland,Md.Allegany
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: MAR 28 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02942

CERTIFICATE OF DEATH

02934

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG (RURAL)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN — Middle LAWRENCE — Last CAREY

4. DATE OF DEATH: Month MARCH — Day 27, — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: AUG. 10, 1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES CAREY

14. MOTHER'S MAIDEN NAME: ADA BLOCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-52-9779T

17. INFORMANT — Address: MRS. ROY KNEPP, 69 PINE ST., FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 days
DUE TO (b): arteriosclerotic Cardiovascular dis — 4 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Jan, 19 67 to March 27 19 67 that (I) (we) last saw the deceased alive on March 27 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3/28/67

22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M. D.

22d. ADDRESS: 2 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAR. 30 '67

23c. NAME OF CEMETERY OR CREMATORY: BLOCHER CEMETERY

23d. LOCATION (City or Town) (County) (State): GARRETT COUNTY, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. RECD BY REGISTRAR — DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02943

CERTIFICATE OF DEATH

02935

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 46 GREEN STREET

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 46 GREEN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELLEN — Last: CLARK
4. DATE OF DEATH: Month: MARCH — Day: 26, — Year: 19 67
SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 6, 1877
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS COSGROVE
14. MOTHER'S MAIDEN NAME: ELLEN MURRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 219-03-8316B
17. INFORMANT — Address: ORPHA CLARK, 46 GREEN ST., FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral arterial occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): arteriosclerotic Cardiovascular Dis. years — over 30 yrs.
DUE TO (c): Severe rheumatoid arthritis
7220
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to March 26 1967, that (I) (we) last saw the deceased alive on March 25 1967, and that death occurred at 2P.M. from causes and on the date stated above

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/28/67
22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M. D.
22d. ADDRESS: 2 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAR. 28, 1967
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: MAR 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02944

CERTIFICATE OF DEATH

02936

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 26 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAVALE
d. STREET ADDRESS: BOX 22
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: LESTER — Middle: HUMPHREY — Last: CORLE

4 DATE OF DEATH: MARCH 18, 19 67

5 SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4-1-89

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PLANT FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: FARMERS DAIRY CO.

11. BIRTHPLACE (County & State, or foreign country): BEDFORD, PA.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: CORLE, ELIAS

14. MOTHER'S MAIDEN NAME: HUNT, EMMA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 215-05-4074

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestion/Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b): Acute Myocardial Infarction — 3 weeks
DUE TO (c): A.S.H.D.

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 19 67 to March 18, 19 67, that (I) (we) last saw the deceased alive on March 18 19 67, and that death occurred at 9:10 P.M. from causes and on the date stated above.

22a SIGNATURE: Wyand F. Doerner Jr. M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-21-67

22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER Jr.

22d ADDRESS: CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 3/21/67

23c NAME OF CEMETERY OR CREMATORY: EVANGELICAL REFORMED CEM.

23d. LOCATION (City or Town) (County) (State): FRIENDS COVE, BEDFORD, PENNA.

24. FUNERAL DIRECTOR: JOHN J. HAFER, JR.

ADDRESS: 230 BALTO. AVE., CUMBERLAND, MD.

25a. REC'D BY REGISTRAR: DATE MAR 23 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02937

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 28 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: West Main Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph — Middle T. — Last Cosgrove
4 DATE OF DEATH: Month March — Day 25 — Year 19 67

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 9-22-1899
9 AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retd. Asst. Mgr.
10b KIND OF BUSINESS OR INDUSTRY: Drug Store
11 BIRTHPLACE (State or foreign country): Frostburg, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Cosgrove
14. MOTHER'S MAIDEN NAME: Elizabeth Mc Callister

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 213-01-5932-A
17 INFORMANT Address: Memorial Hospital

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Hypertensive Cardiovascular disease --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town or county): Cumberland, Md.
22. DATE SIGNED: March 25, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 3-28-67
23c NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery
23d LOCATION (City or Town) (County) (State): Frostburg, Allegany, Md.

24 FUNERAL DIRECTOR: Joseph R. Durst, Sr.,
ADDRESS: Frostburg, Md.
25a REC'D BY REGISTRAR DATE: MAR 29 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death (if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT

02946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02938

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Oldtown, Maryland
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Near Oldtown, Maryland

2 USUAL RESIDENCE (Where deceased lived, if institution Residence Before Admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 317 Pulaski Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leo — Middle: Francis — Last: Costello
4 DATE OF DEATH: Month: March — Day: 1 — Year: 1967
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Feb. 1, 1924
9 AGE (In years last birthday): 43 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Owner
10b KIND OF BUSINESS OR INDUSTRY: Masonary Contractor
11 BIRTHPLACE (State or foreign country): Knoxville, Tenn.
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Michael J. Costello
14 MOTHER'S MAIDEN NAME: Elizabeth Smith Costello Roberts
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service)
16 SOCIAL SECURITY NO:
17 INFORMANT: Brother — Address: Mr. C. J. Costello, Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): (Plane Crash)
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Pilot of Plane which crashed
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m.: 8:10 — March 1 1967
20d INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods, near
20f (City or town) (County) (State): Oldtown, Allegany, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: March 2, 1967
Address (Street, city, town, or county): Cumberland, M.D.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: March 4, 1967
23c NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. RECD BY REGISTRAR DATE: MAR 7 1967
25b REGISTRAR'S SIGNATURE: Charles Judy

VR A15ME (5) 6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02947

CERTIFICATE OF DEATH

02939

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE, MD.
d. STREET ADDRESS: 540 BRADDOCK AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: KIMBERLY — Middle: SUE — Last: DAVIS

4. DATE OF DEATH: Month: MARCH — Day: 5 — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 28, 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LARRY F. DAVIS

14. MOTHER'S MAIDEN NAME: JO ANN L. PRATT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Low Birth Weight - 2 lb 6 3/4. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Premature 5½ mo - 23 week Gestation — 5 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-28 1966 to 3/5 1966, that (I) (we) last saw the deceased alive on 3-5 1966, and that death occurred at 6:15A M, from causes and on the date stated above.

22a. SIGNATURE: H. W. Eliason — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/6/67

22c. PHYSICIAN'S NAME (Type): DR. H. W. ELIASON — 22d. ADDRESS: 203 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: March 6, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park — 23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAR 7 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02940

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Park, Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 65 Ave. L.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Park, Cumberland
d. STREET ADDRESS: 65 Ave. L.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Dietle

4 DATE OF DEATH: Month: March — Day: 21, — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 17, 1893

9 AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Welders Hlpr.

10b KIND OF BUSINESS OR INDUSTRY: Construction

11 BIRTHPLACE (State or foreign country): Somerset Co. Penna.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William H. Dietle

14. MOTHER'S MAIDEN NAME: Christine Nedrow

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: 217-28-0356

17 INFORMANT: Mrs. Cora P. Dietle, 65 Ave. L. Potomac Pk. — Address: Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I — DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS — ---
DUE TO
(c):

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. — Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.

22. DATE SIGNED: 3/21/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 3/25/67

23c NAME OF CEMETERY OR CREMATORY: Grantsville Cemetery

23d LOCATION (City or Town) (County) (State): Grantsville, Garrett, Md.

24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland

25a REC'D BY REGISTRAR DATE: MAR 28 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02949 02941

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 22 McCULLOH STREET

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 22 McCULLOH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN — Middle MAE — Last DOERR

4. DATE OF DEATH: Month MARCH — Day 25, — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: AUG. 17, 1889

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN JOHNSON

14. MOTHER'S MAIDEN NAME: WILHELMINA WRIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-56-8683

17. INFORMANT Address: ARTHUR C. DOERR, FROSTBURG, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Chronic Myocarditis, Pulmonary Edema

DUE TO (b): Arteriosclerotic Cardiovascular disease --

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma of Recto-sigmoid

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 26, 1967

Address (Street, city, town, or county): Cumberland, Maryland (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAR. 29 '67

22c. NAME OF CEMETERY OR CREMATORY: SLEEPY HOLLOW CEMETERY

22d. LOCATION (City, town, or country) (State): TARRYTOWN, N. Y.

23. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

24a. REC'D BY REGISTRAR DATE: MAR 29 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: Th's certificate should be executed with'n 24 hours after death. If any o necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer ctor. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of H th, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02950 02942

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1HR. 30 Min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNSYLVANIA b. COUNTY: BEDFORD
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RD#1 Hyndman, P.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Florence Middle: Elizabeth Last: Emerick
4. DATE OF DEATH: Month: March Day: 13 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 25, 1891
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Rush, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel F. Wilson
14. MOTHER'S MAIDEN NAME: Maria Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 211-40-1222T
17. INFORMANT Address: Mr. Russell Emerick, Hyndman, PA. RD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1.26.67, 19__, to 3.13.67, 19__, that (I) (we) last saw the deceased alive on 3.13.67 19__, and that death occurred at 9:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William P. James, MD M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3.14.67
22c. PHYSICIAN'S NAME (Type): William P. Iames, M.D.
22d. ADDRESS: 441 N. Centre St, Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Pabb Alto Cemetery
23d. LOCATION (City, town or county) (State): Hyndman, Pa. RD#1

24. FUNERAL DIRECTOR: Harvey A. Zeigler
ADDRESS: Hyndman, Pennsylvania
25a. REC'D BY REGISTRAR DATE: MAR 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02951 — 02943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and if any, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c LENGTH OF STAY IN 1b: LIFE	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA MEMORIAL HOSPITAL	d STREET ADDRESS: 628 LINCOLN STREET e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: MABEL	Middle	Last: FERGUSON	4. DATE OF DEATH	Month: MARCH	Day: 24	Year: 19 67
5 SEX: FEMALE	6 COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: JULY 9, 1901	9. AGE (In years last birthday): 65 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME	11 BIRTHPLACE (County & State, or foreign country): BERLIN, PA.	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: DANIEL SWARNER		14. MOTHER'S MAIDEN NAME: AGNES IRVIN	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dates of service)	16. SOCIAL SECURITY NO.: NONE	17. INFORMANT: ANDREW FERGUSON — Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerotic Cardio-Vascular Disease. — 4201 — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/24/61, 19__, to March, 1967 that (I) (we) last saw the deceased alive on 3/17/67 19__, and that death occurred at 8:00 P.M. from causes and on the date stated above.

22a. SIGNATURE: G. O. Himmelwright M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 3.27.67	
22c. PHYSICIAN'S NAME (Type): G. O. HIMMELWRIGHT, M.D.	22d ADDRESS: 133 VIRGINIA AVE. CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE THEREOF: MARCH 28, 1967	23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD.	
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: MAR 29 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02952 02944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. 2, BOX 126A, CUMBERLAND, MD.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BRENDA Middle LEE Last GABLE

4. DATE OF DEATH: Month MARCH Day 20 Year 1967

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 25-66
9 AGE (In years last birthday): *
IF UNDER 1 YEAR: Months 11 Days 20
IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN GABLE
14. MOTHER'S MAIDEN NAME: JUDY ~~XXXXXXXX~~ SEARS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CARDIAC FAILURE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): PRIMARY MYOCARDIAL DISEASE
DUE TO
(c): METABOLIC DISORDER

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 1:20P M, from causes and on the date stated above.

22a SIGNATURE: Robert D. Brodell M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): DR. R. D. ~~XXXXXX~~ BRODELL
22d ADDRESS: 500 GREEN ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/23/67
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS: H. Lee Silcox Cumberland Maryland 21502
25a. RECD BY REGISTRAR DATE: MAR 28 1967
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02953

CERTIFICATE OF DEATH

Reg. Dist. No. 02945

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 102 Weigand Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
d. STREET ADDRESS: 102 Weigand Drove
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sara — Middle: Jane — Last: Galford

4. DATE OF DEATH: Month: March — Day: 6, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/5/1893

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cass, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Cassell

14. MOTHER'S MAIDEN NAME: Louise (Cassell) Cassell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mrs. Mary Bittner — Address: 102 Weigand Drive, LaVale, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Cervix — 2 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 19 56, to 3.6.67, 19, that I last saw the deceased alive on 2.27.67, 19, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. Ianes M.D.
ADDRESS (Street, city or town, state): 441 N. Centre St. Cumb. M d.
DATE SIGNED: 3/9/67

PHYSICIAN'S NAME (Type): William P. Ianes, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/67
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d LOCATION (City, town, or county) (State): Cumberland, Allegany, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.

24a REC'D BY REGISTRAR DATE: MAR 13 1967
24b REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02954

CERTIFICATE OF DEATH

02946

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 20 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   d. STREET ADDRESS: 26 N. MECHANIC ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA — Middle L. — Last GAUGHAN

4. DATE OF DEATH: Month MARCH — Day 14 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-5-95

9. AGE (In years last birthday): 71 yrs
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): ELK GARDEN, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE WARNER

14. MOTHER'S MAIDEN NAME: SUSAN KENNY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-20-6424

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
    DUE TO (b): Arteriosclerotic cardiovascular disease — years
    DUE TO (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 22nd 19 67 to March 14 19 67 that (I) (we) last saw the deceased alive on March 14 19 67 and that death occurred at 7:00A M, from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-14-67

22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER, JR.

22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/16/67

23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park

23d. LOCATION (City or Town): Near Cumberland (County): Alleg (State): Md.

24. FUNERAL DIRECTOR: John J. Hafer, Jr. — ADDRESS: John J. Hafer, Jr., 230 Baltimore Ave. Cumberland Md

25a. REC'D BY REGISTRAR DATE: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

02955

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02947

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rawlings
d. STREET ADDRESS: Along U. S. Rt. # 220
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Betsy — Middle: Ross — Last: Gordon

4. DATE OF DEATH: Month: March — Day: 26, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 6, 1924

9. AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Former machine opr.

10b. KIND OF BUSINESS OR INDUSTRY: Aircraft Factory

11. BIRTHPLACE (State or foreign country): Zihlman

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas R. Morgan

14. MOTHER'S MAIDEN NAME: Nannie B. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mr. Quinton Gordon, Rawlings, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gunshot of Head — INTERVAL BETWEEN ONSET AND DEATH: Sudden
476X
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): (Self-inflicted) — --
DUE TO (c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒ Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: March 26, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/67
23c. NAME OF CEMETERY OR CREMATORY: Biertown Cemetery
23d. LOCATION (City or Town) (County) (State): nr. Rawlings, Allegany Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02956 02948

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SAC ED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 24 8½ MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID Middle E. Last GUNTER

4. DATE OF DEATH: Month MAR. Day 19 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 17, 1894

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOOD CONSULTANT

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM R. GUNTER

14. MOTHER'S MAIDEN NAME: ANNIE S. WEHNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 220-16-5706A

17. INFORMANT Address: EMERG ENCY ROOM CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS WITH THROMBOSIS — ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: March 19, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MARCH 22, 1967

23c. NAME OF CEMETERY OR CREMATORY: FB'G. MEMORIAL PARK

23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: MAR 23 1967

25b. REGISTRAR'S SIGNATURE: J Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02957

CERTIFICATE OF DEATH

02949

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: 4 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   d. STREET ADDRESS: RT. 2, BOX 356
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EDITH — Middle: B. — Last: HAINES

4. **DATE OF DEATH**: Month: MARCH — Day: 5, — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 20, 1895

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT NELSON

14. MOTHER'S MAIDEN NAME: ETTA HAINES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-6091B

17. INFORMANT — Address: T. LEE HAINES, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinomatosis, primary in upper G.I. tract.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/22/66, 19___, to 10/5/67, 19___, that (I) (we) last saw the deceased alive on 10/5/67 19___, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE: Alvin J. Walters M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/6/67

22c. PHYSICIAN'S NAME (Type): ALVIN J. WALTERS, M. D.

22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAR. 8 '67

23c. NAME OF CEMETERY OR CREMATORY: DAVIS MEMORIAL CEMETERY

23d. LOCATION (City or Town) (County) (State): OLDTOWN RD., CUMBERLAND, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a. REC'D BY REGISTRAR: MAR 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02958

CERTIFICATE OF DEATH

02950

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 3 WKS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN — Middle E. — Last HARDEN
4. DATE OF DEATH: Month MARCH — Day 30, — Year 19 67

5 SEX: MALE
6 COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 25, 1902
9 AGE (In years Last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESTAURANT
10b KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD HARDEN
14. MOTHER'S MAIDEN NAME: ANNIE THORP

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO.: 213-10-9111
17 INFORMANT Address: MRS. MARGARET W. HARDEN, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Fulminating Bilateral Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
490 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive Heart failure — 2 weeks
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 10, 1967, to March 30 1967, that (I) (we) last saw the deceased alive on March 30 1967, and that death occurred at 12:35 M, from causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/31/67
22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M. D.
22d. ADDRESS: 2 BROADWAY, FROSTBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APRIL 2 '67
23c. NAME OF CEMETERY OR CREMATORY: METHODIST CEMTERY
23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, MD.
24 FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: APR 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Item #0337 3/24/67 pc

02953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02951

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 20 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 720 Lafayette Avenue

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 01.1
d STREET ADDRESS: 720 Lafayette Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ethel — Middle: Mae — Last: Harmon
4 DATE OF DEATH: Month: March — Day: 17 — Year: 19 67

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Aug. 27, 1901
9 AGE (In years last birthday): 64 65 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b KIND OF BUSINESS OR INDUSTRY: Y. M.C.A.
11 BIRTHPLACE (State or foreign country): St. George, W. Va.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Enoch Adam Wiles
14. MOTHER'S MAIDEN NAME: Mary Loretta Bohon

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: Mrs. Stella Sheppard, Address: Old Furnace Rd., W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis — ------
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D — Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rt.9 Cumberland, Md.
22. DATE SIGNED: 3-17-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: March 19, 1967
23c NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
23d LOCATION (City or Town) (County) (State): Near Parsons, W. Va.

24 FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a REC'D BY REGISTRAR: MAR 23 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02960 02952

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital D. O. A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 174 Baltimore St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter; Middle M.; Last Herboldsheimer

4. DATE OF DEATH: Month March; Day 16; Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: October 21, 1900

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): News Stand Operator

10b. KIND OF BUSINESS OR INDUSTRY: Sales of News

11. BIRTHPLACE (State or foreign country): Westernport Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George D. Herboldsheimer

14. MOTHER'S MAIDEN NAME: Elizabeth Herboldsheimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Wm. Speir
Address: Rockledge Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis — ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: March 16, 1967

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/27/67

23c. NAME OF CEMETERY OR CREMATORY: Hillcreast Burial Park

23d. LOCATION (City or town, county) (State): Cumberland Maryland

24. FUNERAL DIRECTOR: Louis Stein Inc.
ADDRESS: 117 Frederick

25a. REC'D BY REGISTRAR (DATE): MAR 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Lugg

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

1

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02953

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Flintstone
d. STREET ADDRESS: Rt. #1, Box 96
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Dorothy — Middle: Renee ~~Prince~~ — Last: Johns

4 DATE OF DEATH: Month: 3 — Day: 8 — Year: 1967

5 SEX: female

6. COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 2/22/64

9 AGE (In years last birthday): 3 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------

10b KIND OF BUSINESS OR INDUSTRY: ---------

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Harold Burton Johns

14. MOTHER'S MAIDEN NAME: Anna Ruth Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: None

17. INFORMANT Address: Harold B. Johns, Route 1, Box 96, Flintstone Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Pulmonary Congestion and Edema — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Patent Interventricular Septum — -----
DUE TO
(c): (Congenital)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: March 8, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Mar. 10, 1967
23c NAME OF CEMETERY OR CREMATORY: Buckhannon Memorial Park
23d LOCATION (City or Town) (County) (State): Buckhannon Upshur W. Va.

24. FUNERAL DIRECTOR ADDRESS: Leah F. Hafer, 230 Balto Ave., Cumberland, Md

25a. RECD BY REGISTRAR: MAR 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02962 02954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Maryland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 606 Greene St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanor (AKA Charles) Middle: Humbird Last: Johnston

4. DATE OF DEATH: Month: March Day: 25 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 17., 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Jewelry Store
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Charles
14. MOTHER'S MAIDEN NAME: Bertie Hitchcook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: 577-14-1896
17. INFORMANT: Mr. William E. Johnston Address: 3409 Ripple Rd. Balto. 21207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma R. Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Uraemia — 2 wks.

DUE TO

(c): R. Pleural Effusion — 6 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 24, 1967 to Mar. 25, 1967, that (I) (we) last saw the deceased alive on Mar. 24 1967, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clay E Durrett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/25/67
22c. PHYSICIAN'S NAME (Type): Clay E. Durrett
22d. ADDRESS: 236 Kelly Ave Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/28/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Allegany Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. Wayne George Cumberland, Maryland
25a. RECD BY REGISTRAR DATE: MAR 29 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02963 Item #9 Film #G330 3/13/67 DV

CERTIFICATE OF DEATH

02955

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 427 N. Centre St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: McClellan Middle: NMI Last: Kifer

4. DATE OF DEATH: Month: 3 Day: 5 Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/24/91

9. AGE (In years last birthday): 7675 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: AUTO SALES

11. BIRTHPLACE (County & State, or foreign country): ALLEGANY CO. MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Vernon Kifer

14. MOTHER'S MAIDEN NAME: Maria(Chaney) Kifer (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212 24 0443A

17. INFORMANT: patient's chart
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — 20 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/2, 1967, to 3/5, 1967, that (I) (we) last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Dr. Glick & Spiggle, M.D.

22d. ADDRESS 122 S. Smallwood St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MARCH 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: GLENDALE CEMETERY

23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: MAR 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02964

CERTIFICATE OF DEATH

02956

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: WASHINGTON-LEE APTS.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ESTHER — Middle PLATT — Last KLAWAN

4 DATE OF DEATH: Month MARCH — Day 25, — Year 1967.

5 SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-25-1882

9 AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): LITHUANIA

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: ~~PLATT~~ LAZAR PLATT

14. MOTHER'S MAIDEN NAME: ANNA ~~FRIEDBERG~~ FRIEDBERG

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: 220-44-5687

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 14 DAYS
DUE TO
(b): ENDOMETRIAL CARCINOMA WITH — 4 MOS ??
DUE TO
(c): EXTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
172X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/16/67, 1967, to 3/25, 1967, that (I) (we) last saw the deceased alive on 3-25- 1967, and that death occurred at 8:15 A.M., from causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/26/67

22c. PHYSICIAN'S NAME (Type): DR. SAMUEL M. JACOBSON

22d. ADDRESS: 50 PERSHING ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/27/67

23c. NAME OF CEMETERY OR CREMATORY: East View Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Alleg Md

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Jr. 230 Balto Ave. Cumberland Md

25a. REC'D BY REGISTRAR: MAR 28 1967

25b. REGISTRAR'S SIGNATURE: M. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02965

CERTIFICATE OF DEATH

02957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 2DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a STATE: MARYLAND — b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BARTON
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First CHARLES — Middle — Last KYLE

4. DATE OF DEATH: Month MARCH — Day 11 — Year 19 67

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 9-26-1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): MOSCOW, MARYLAND

12 CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: FRANK KYLE

14. MOTHER'S MAIDEN NAME: ANNIE LEE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: 217-05-0987

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia left lower — INTERVAL BETWEEN ONSET AND DEATH: 2 days ?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Dehydration, Metabolic Acidosis ?
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with depression, Coronary Arteriosclerosis, Myocardial Fib

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 9, 19 67 to Mar. 11, 19 67 that (I) (we) last saw the deceased alive on Mar. 10, 19 67, and that death occurred at 7:20 PM from causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Mar. 14, 1967

22c. PHYSICIAN'S NAME (Type): S.M. JACOBSON, M.D.

22d. ADDRESS: 50 PERSHING ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/14/67

23c NAME OF CEMETERY OR CREMATORY: Rest Lawn

23d LOCATION (City or Town) (County) (State): LaVale Md.

24 FUNERAL DIRECTOR — ADDRESS: Westernport, Md.

25a RECD BY REGISTRAR DATE: MAR 16 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02966 02958

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md.
c. LENGTH OF STAY IN 1b: 24 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md.
d. STREET ADDRESS: 117 Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vincent — Middle: Paul — Last: Leasure Jr.

4. DATE OF DEATH: Month: March — Day: 15 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1942

9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Funeral Director

10b. KIND OF BUSINESS OR INDUSTRY: Funeral Home

11. BIRTHPLACE (County & State, or foreign country): Allegany Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vincent Paul Leasure Sr.

14. MOTHER'S MAIDEN NAME: Josephine C. Schute

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Vincent P. Leasure Sr. — Address: 117 Frederick St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the intestine — INTERVAL BETWEEN ONSET AND DEATH: 14 mo.

1539

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Abdominal carcinomatosis — 14 mo.

DUE TO (c) Intestinal obstruction — 1 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cacheria

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): none

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 8, 19 66, to March 15, 19 67, that (I) (we) last saw the deceased alive on March 15, 19 67, and that death occurred at 4. A.M., from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-16-67

22c. PHYSICIAN'S NAME (Type): James P. Hallinan M. D.

22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/18/67

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery

23d. LOCATION (City, town or county) (State): Cumberland Maryland

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: 117 Frederick St

25a. RECD BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02967

CERTIFICATE OF DEATH

02959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 MO. 22 DA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: WEST VIRGINIA — COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PIEDMONT
d. STREET ADDRESS: 33 THIRD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARIE — Middle: E. — Last: LE FEVRE

4. DATE OF DEATH: Month: March — Day: 31, — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 30, 1998

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State or foreign country): Keyser, W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LUKE MC DOWELL

14. MOTHER'S MAIDEN NAME: MARY E. DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 235-80-8283

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma R. breast — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hydrothorax — 4 mos
DUE TO
(c): Carcinomatosis — 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1- , 1967 to 4/31, 1967, that (I) (we) last saw the deceased alive on 3/31/67, 1967, and that death occurred at 8:55 M. from causes and on the date stated above.

22a. SIGNATURE: W Royce Hodges — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Apr. 4, 1967

22c. PHYSICIAN'S NAME (Type): W. ROYCE HODGES, M.D.

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-4-67

23c. NAME OF CEMETERY OR CREMATORY: Potomac V.M.Park

23d. LOCATION (City or Town) (County) (State): Keyser, W.Va.

24. FUNERAL DIRECTOR: Thomas L. Smith Jr. — ADDRESS: Keyser, W.Va.

25a. REC'D BY REGISTRAR: APR 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02968

CERTIFICATE OF DEATH

02960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 3 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: MORNING SIDE DRIVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VINCENT — Middle: JOSEPH — Last: LINDNER

4. DATE OF DEATH: Month: 3/7/67 — Day — Year: 19

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/9/1893

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Repairman

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co

11. BIRTHPLACE (County & State, or foreign country): Allegany County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Lindner

14. MOTHER'S MAIDEN NAME: Florence Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: PT'S CHART

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

1681

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 6, 19 66 to 3/7, 19 67, that (I) (we) last saw the deceased alive on 3/4 19 67, and that death occurred at 7:4 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 3/7/67

22c. PHYSICIAN'S NAME (Type): DRS. GLICK & SPIGGLE

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/9/67

23c. NAME OF CEMETERY OR CREMATORY: St Peter + Paul Cem

23d. LOCATION (City, town or county) (State): Cumberland Md

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: MAR 8 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02969 02961

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS: CHURCH HILL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MESHIACK Middle LOGSDON Last

4. DATE OF DEATH: Month MARCH Day 28, Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 31, 1882
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABORER
10b. KIND OF BUSINESS OR INDUSTRY: FOUNDRY
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PETER LOGSDON
14. MOTHER'S MAIDEN NAME: MARY ELLEN BRANNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-036475
17. INFORMANT Address: MRS. CECILIA B. LOGSDON, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio-vascular dis — 4 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March 24, 1967, to March 28 1967, that (I) (we) last saw the deceased alive on March 28 1967, and that death occurred at 10 P.M, from causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/30/67
22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M. D.
22d. ADDRESS: 2 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APR. 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICK'S CEMETERY
23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: APR 3 1967
25b. REGISTRAR'S SIGNATURE: Juliette Griggs

7 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02970

CERTIFICATE OF DEATH

02962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 4-5 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 49 BROADWAY

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 49 BROADWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISAAC Middle T. Last LOVE
4. DATE OF DEATH: Month MARCH Day 9, Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 20, 1896
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: ECONOMY STORE
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ISAAC LOVE
14. MOTHER'S MAIDEN NAME: MARY LAIRD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 214-32-3072
17. INFORMANT: MRS. STELLA BOETTNER, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute cerebral accident — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cerebral arteriosclerosis — Not known
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 15, 1967, to March 9, 1967, that (I) (we) last saw the deceased alive on March 5 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: G Paige Strong M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/9/67
22c. PHYSICIAN'S NAME (Type): A. PAIGE STRONG, M. D.
22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAR. 12 '67
23c. NAME OF CEMETERY OR CREMATORY: FB'G. MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: MAR 13 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items #8 & 9 Film G387 4/17/67 pc

02971

CERTIFICATE OF DEATH

02963

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 1 hr. 15min.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: WEST VIRGINIA
   b. COUNTY: MINERAL ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PIEDMONT
   d. STREET ADDRESS: 14 JAMES STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Teresa (TERESA) Middle: A. Last: LUPIS

4. DATE OF DEATH: Month: MAR. Day: 11 Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1893

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicola Argiro

14. MOTHER'S MAIDEN NAME: Angela Fanto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Patient's Emergency Room Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

4500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis — 20 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/ , 1966, to 3/11 , 1967, that (I) (we) last saw the deceased alive on 3/11 19 67, and that death occurred at 12:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Wm Spiggle — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/12/67

22c. PHYSICIAN'S NAME (Type): Wayne C. Spiggle

22d. ADDRESS: 126 N. Smallwood St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/14/67

23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

23d. LOCATION (City, town or county) (State): Westernport, Alle Md.

24. FUNERAL DIRECTOR: W. T. Fiddock Jr. — ADDRESS: Piedmont, W.Va.

25a. REC'D BY REGISTRAR: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02972

CERTIFICATE OF DEATH

02964

1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 3 HRS. 50 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE
d. STREET ADDRESS 5 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MICHAEL Middle P. Last LYNCH
4. DATE OF DEATH Month MARCH Day 29 Year 19 67
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 5-2-96
9. AGE (In years last birthday) ~~70~~ yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman
10b. KIND OF BUSINESS OR INDUSTRY C & P R R
11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME JOHN LYNCH
14. MOTHER'S MAIDEN NAME MARGARET FLOOD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW 1
16. SOCIAL SECURITY NO. 712-14-1567
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 4 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial Asthma, Pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950, 19 3-30 to P. M. 3-29, 19 67 that (I) (we) last saw the deceased alive on 3-29 19 67, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE William P James M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 3/31/67
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES
22d. ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/1/67
23c. NAME OF CEMETERY OR CREMATORY Sts Peter & Paul's Cath Cem
23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md

24. FUNERAL DIRECTOR John J. Hafer, Jr. ADDRESS John J. Hafer, Jr. 230 Balto Ave. Cumberland, Md.
25a. REC'D BY REGISTRAR APR 3 1967
25b. REGISTRAR'S SIGNATURE Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02973 02965

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND / DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
d. STREET ADDRESS: 943 Weires Ave.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie Middle: Winona Last: Mangus
4. DATE OF DEATH: Month: March Day: 26 Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 10, 1890
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Berkeley Springs, W. Va.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: John Courtney
14. MOTHER'S MAIDEN NAME: Lillian Lutman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. Dorsey Mangus, La Vale, Md. Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 26, 1967
Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar.29,1967
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or country) (State): Cumberland, Md. Allegany

23. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 28 1967
24b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02974 02966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 46 Marion Street

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 46 Marion Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ida — Middle: Frances — Last: Martin

4. DATE OF DEATH: Month: March — Day: 5 — Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: October 18, 1868

9 AGE (In years last birthday): 98 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State or foreign country): Hartmansville W. Va

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John H. Bisel

14. MOTHER'S MAIDEN NAME: Anna Wingert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: None

17. INFORMANT: Carmelita Mamajek — Address: 46 Marion Street, Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hypertensive Arteriosclerotic C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(b): Cerebral Sclerosis — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to March, 19 67, that (I) (we) last saw the deceased alive on March 10 19 67 and that death occurred at 9:34 A.M., from causes and on the date stated above.

22a. SIGNATURE: David T. Lees — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: March 67

22c. PHYSICIAN'S NAME (Type): DAVID T. LEES

22d. ADDRESS: 76 Mountcastle Dr. Cumberland Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/8/67

23c NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland

25a. REC'D BY REG. STRAR (MO.) DATE: MAR 9 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02975 02967

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Corriganville
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Corriganville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Annie	(Corley)	May	March	8	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		October 2, 1884	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Manns Choice, P., RD#1	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Metzger Corley	Maria Mowery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	212-54-8187	Miss Ethel May, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PE[illegible] YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. RD#9 Cumberland, Md. (Address (Street, City, town, or county))

DATE SIGNED: March 8, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	March 11, 1967	Dry Ridge Cemetery	Manns Choice, Pa. RD#1

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler	Hyndman, Pennsylvania	MAR 1 3 1967	J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02968

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 11 Hours.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 209 E. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle P. — Last McGUIRE
4. DATE OF DEATH: Month March — Day 26, — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4, 1915
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAXI DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick McGuire
14. MOTHER'S MAIDEN NAME: Agnes Arnold
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 216-09-3825
17. INFORMANT: Mrs. Ruth McGuire, Address 209 E. Main St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ruptured Aorta — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fractured Sternum — "
DUE TO
(c): (Auto Accident) — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of Auto in Rear End Collision
20c. TIME OF INJURY Month, Day, Year Hour a.m.: 3:00 — March 26,67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt.40 East of
20f. (City or town) (County) (State): Grantsville,Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection XX, Inquiry XX and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: B. Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED CAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: March 26, 1967
Address (Street, city, town or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 29 '67
23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery
23d. LOCATION (City or Town) (County) (State): Frostburg, Md.

24. FUNERAL DIRECTOR: Joseph R. Durst, Sr., ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR: MAR 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

3 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02977 **CERTIFICATE OF DEATH** 02969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
10 M 1/66

1. PLACE OF DEATH a. COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND b. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND c. LENGTH OF STAY IN 1b: 72 hrs DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL	d. STREET ADDRESS: 106 POTOMAC STREET e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: MARGARETTA	Middle: P.	Last: MC HUGH	4. DATE OF DEATH	Month: MARCH	Day: 25,	Year: 19 67
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 11-19-1894	9. AGE (In years last birthday): 72 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Ownhome	11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME: JOHN HAELEY	14. MOTHER'S MAIDEN NAME: GRACE Star Junction Gibbons						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL- CUMBERLAND, MD.	Address				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY.		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Diabetes Mellitus	2 yrs
DUE TO (b)	Acute Cardiac Failure	3 days
DUE TO (c)	Pulmonary Edema	3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Mar. 16, 19 67 to Mar. 25, 19 67, that (I) (we) last saw the deceased alive on Mar. 24 19 67, and that death occurred at 8:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 3/28/67	
22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT	22d. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 3-28-67	23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery	23d. LOCATION (City or Town): Cumberland, Md.	(County) (State)
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: MAR 28 1967	25b. REGISTRAR'S SIGNATURE: [signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02970

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 5 Cumberland (rural)
d. STREET ADDRESS: Fairgo
e. RESIDENCE ON A FARM? YES ☐ NO ☒

99

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Maria	Helen	McKenzie	March	20,	1967

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White		11/3/1900	66 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Cumberland, Md.	U.S.A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Goldsworthy	Anna M. Helferich

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17. INFORMANT Address
No.	None	Mr. Paul W. McKenzie Rt. # 5 Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — ----
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: March 20, 1967
Address (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	3/23/67	SS. Peter & Paul Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md.	MAR 27 1967	J. Charles Judge

VR A15ME (6M 1/66) BP

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any de ay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (9) 6M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02979

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02971

PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 43 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 4, Christie Road

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Route 4, Christie Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ray — Middle: Hummel — Last: Merrill

4 DATE OF DEATH: Month: March — Day: 5 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 2, 1901

9 AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Garment

11 BIRTHPLACE (State or foreign country): Garrett, County, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: James Merrill

14 MOTHER'S MAIDEN NAME: Drucilla Hummel

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): no

16 SOCIAL SECURITY NO:

17 INFORMANT — Address: Mrs. Ethel Merrill, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion, left — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Thrombosis, left — ---

DUE TO (c): Coronary Sclerosis — ------

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES XX NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour, a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

22. DATE SIGNED: March 5, 1967

Address (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 8, 1967

23c NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a RECD BY REGISTRAR — DATE: MAR 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02980 02972

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL, CUMBERLAND, MD.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 215 HUMBIRD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD — Middle V. — Last MILLER

4. DATE OF DEATH: Month MARCH — Day 31 — Year 1967

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
MALE	WHITE	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	JAN. 27, 1904	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED ENGINEER	B & O R R	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES W. MILLER	BESSIE VALENTINE

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
NO	214-05-9242	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Resp Collapse
DUE TO (b): Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/1/63, 19__, to 3/31/67, 19__, that (I) (we) last saw the deceased alive on 3/31/67, 19__, and that death occurred at 8:35 P.M. from causes and on the date stated above

22a. SIGNATURE M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — **22b. DATE SIGNED** 4/3/67

22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS, M.D. — **22d. ADDRESS** 122 S. CENTRE ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/4/67	Zion Memorial Park	Near Cumberland Alleg Md

24. FUNERAL DIRECTOR John J. Hafer, Jr. — **ADDRESS** John J. Hafer, Jr. 230 Balto Ave. Cumberland, Md.

25a. REC'D BY REGISTRAR APR 5 1967 — **25b. REGISTRAR'S SIGNATURE** Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0298 — 02973

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 5 Bellvue St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrl — Middle: Iva — Last: Mull
4. DATE OF DEATH: Month: 3 — Day: 6 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/12/99
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Everett, Penna.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James E. Evans
14. MOTHER'S MAIDEN NAME: Emma Merkel (Mearkle)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214 05 9581
17. INFORMANT: patient's chart & Bobby Price Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH: 9 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X
DUE TO (b): Cachexia — 4 mo.
DUE TO (c): None
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 17, 19 66, to March 6, 19 67, that (I) (we) last saw the deceased alive on March 6, 19 67, and that death occurred at 12 M. from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-6-67
22c. PHYSICIAN'S NAME (Type): James P. Hallinan M. D.
22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Madley Cemetery
23d. LOCATION (City, town or county) (State): Bedford Co., Penna.

24. FUNERAL DIRECTOR: Joseph W. Stuart
ADDRESS: Everett, Pa.
25a. REC'D BY REGISTRAR DATE: MAR 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02982 02974

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 23 GRAND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL Middle E. Last NIXON

4. DATE OF DEATH: Month MARCH Day 7 Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-12-88

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED HOSLER

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.CO.

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES E. NIXON

14. MOTHER'S MAIDEN NAME: MARTHA L. HARDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): War I yes

16. SOCIAL SECURITY NO:

17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(b) Myocarditis & Decompensation — 3 mon.
DUE TO
(c) Broncho - Pneumonia — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4222

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 3, 1967 to Mar. 7, 1967, that (I) (we) last saw the deceased alive on Mar. 7 1967, and that death occurred at 12:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/7/67

22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT

22d. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 9,1967

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. RECD BY REGISTRAR DATE: MAR 14 1967

25b. REGISTRAR'S SIGNATURE: Jolanta Jurga

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02983 02975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Mt. Savage,
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: A. Last: O'Neal, Sr.
4. DATE OF DEATH: Month: 3 Day: 17 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/24/91
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: railroad eng.
11. BIRTHPLACE (County & State, or foreign country): Penna. (COLEMONT
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Hartman O'Neal
14. MOTHER'S MAIDEN NAME: Hester Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 712-14-1576
17. INFORMANT: patient's chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute myocardial Infarction	6 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	2 yrs.
DUE TO (c)	Coronary sclerosis	10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 8, , 1966, to March 17, , 19 67, that (I) (we) last saw the deceased alive on March 17, 19 67, and that death occurred at 3.30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James T. Hallinan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-17-67
22c. PHYSICIAN'S NAME (Type): Dr. James Hallinan
22d. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: March 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Savage Meth. Cem.
23d. LOCATION (City, town or county) (State): Mt. Savage, Maryland
24. FUNERAL DIRECTOR ADDRESS: MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN ST., FROSTBURG
25a. REC'D BY REGISTRAR: MAR 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT. M 02984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02976

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 188 N. CENTRE ST.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — 01-1
d. STREET ADDRESS: 188 N. CENTRE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: George — Middle: Edwin — Last: Parker

4 DATE OF DEATH: Month: March — Day: 12 — Year: 19 67

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: NOV. 7, 1885

9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): YARD CONDUCTOR (RET.)

10b KIND OF BUSINESS OR INDUSTRY: RAILROAD

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: HENRY W. PARKER

14 MOTHER'S MAIDEN NAME: JANE ANN WHITE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: 705 09 3688

17 INFORMANT: GEORGE C. PARKER, POTOMAC PARK, CUMBERLAND, MD.
Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Sclerosis — ----
DUE TO
(c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

1201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Maryland

22. DATE SIGNED: March 12, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: MARCH 15, 1967

23c NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY

23d LOCATION (City or Town) (County) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.

25a REC'D BY REGISTRAR DATE: MAR 15 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02983

CERTIFICATE OF DEATH

02977

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 8 DAYS
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW
d. STREET ADDRESS: ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle C. Last PLATT
4. DATE OF DEATH: Month MARCH Day 7 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-23-06
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector
10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.
11. BIRTHPLACE (County & State, or foreign country): KEIFER, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: WILLIAM PLATT
14. MOTHER'S MAIDEN NAME: SLIDER, NANCY ELLEN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 214-07-0695
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic C.V. Disease
DUE TO
(b): Congestive failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Since Oct '56

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m. a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-17-56, 196 : 20a P.M. 3-7-, 1967 that (I) (~~we~~) last saw the deceased alive on 3-7-1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Wm. F. Williams M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-8-67
22c. PHYSICIAN'S NAME (Type): W. F. WILLIAMS
22d. ADDRESS: CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/10/1967
23c. NAME OF CEMETERY OR CREMATORY: Sulphur Springs Cem.
23d. LOCATION (City or Town) (County) (State): Paw Paw, W. Va.
24. FUNERAL DIRECTOR ADDRESS: Johnson Funeral Homes Berkeley Spgs. W
25a. RECD BY REGISTRAR DATE: MAR 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02986

CERTIFICATE OF DEATH

02978

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 38 MESHACK FROST VILLAGE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARY — Middle V. — Last PUGH

4 DATE OF DEATH: Month MARCH — Day 22, — Year 19 67

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: MARCH 16, 1901

9. AGE (In years last birthday): 66 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b KIND OF BUSINESS OR INDUSTRY: PRIVATE HOMES

11 BIRTHPLACE (County & State, or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RICHARD A. PUGH

14. MOTHER'S MAIDEN NAME: SARAH FREAL

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-48-2666

17. INFORMANT Address: WM. F. PUGH, FROSTBURG, MD. RT. 1, BOX 485-A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic Cardio-
DUE TO (c): vascular Disease — years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March 15, 1967 to March 22 1967 that (I) (we) last saw the deceased alive on March 22 1967, and that death occurred at 1 45 M, from causes and on the date stated above.

22a. SIGNATURE: John B. Davis M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/23/67

22c. PHYSICIAN'S NAME (Type): JOHN B. DAVIS, M. D.

22d ADDRESS: 2 BROADWAY, FROSTBURG, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAR. 25 '67

23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY

23d LOCATION (City or Town) (County) (State): FROSTBURG, MD.

24 FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, SR., FROSTBURG, MD.

25a REC'D BY REGISTRAR: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02987

CERTIFICATE OF DEATH

02979

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MENORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 511 MARYLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: ELIZABETH — Middle: B. — Last: RAVENSCROFT

4. DATE OF DEATH: Month: MARCH — Day: 20 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-13-1880

9. AGE (In years last birthday): 86 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WHEELING, W. VA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM KALBAUGH

14. MOTHER'S MAIDEN NAME: BERTHA LANDKROHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO.:

17 INFORMANT — Address: CUMBERLAND, MEMORIAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO (b): Generalized Arteriosclerotic Cardiovascular
DUE TO (c): Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/1/67, 19__ to 3/19/67 19__, that (I) (we) last saw the deceased alive on 3/19/67 19__, and that death occurred at 12:06 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/20/67

22c. PHYSICIAN'S NAME (Type): DR. G. O. HUMMELWRIGHT

22d. ADDRESS: VIRGINIA AVE.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/23/67

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION (City or Town) (County) (State): Westernport Md.

24. FUNERAL DIRECTOR: [signature]

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02988 02980

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: PENNA. b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOX 462, HYNDMAN, PA.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Twin I — First: BABY BOY — Middle: JERRY LYNN — Last: RINGLER

4. DATE OF DEATH: Month: MARCH Day: 6 Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-6-67

9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours: 6 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): CUMB, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT L. RINGLER

14. MOTHER'S MAIDEN NAME: BRENDA L. STUBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): 776X Prematurity — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19__ to _____, 19__, that (I) (we) last saw the deceased alive on March 19 67 and that death occurred at 7:30P M, from causes and on the date stated above.

22a. SIGNATURE: David Ransom M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): DR. LELAND RANSOM

22d. ADDRESS: 401 DECATUR ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Madley Cemetery

23d. LOCATION (City or Town) (County) (State): Buffalo Mills, Bedford Co. Pa

24. FUNERAL DIRECTOR: Harvey A. Zeigler

ADDRESS: Hyndman, Pennsylvania

25a. FILED BY REGISTRAR: MAR 13 1967

25b. REGISTRAR'S SIGNATURE: Jeanette Gregg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02989

CERTIFICATE OF DEATH

02981

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1½ HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: PENNA — b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOX 462, HYNDMAN, PA.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Twin II — First: BABY BOY — Middle: TERRY LEE — Last: RINGLER

4. DATE OF DEATH: Month: MARCH — Day: 6 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-6-67

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: 1 — Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT L. RINGLER

14. MOTHER'S MAIDEN NAME: BRENDA L. STUBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on March 6 19 67, and that death occurred at 3:P M, from causes and on the date stated above.

22a. SIGNATURE: Leland Ransom M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): DR. LELAND RANSOM

22d. ADDRESS: 401 DECATUR ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: March 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Madley Cmetery

23d. LOCATION (City or Town) (County) (State): Buffalo Mills, Bedford Co., Pa.

24. FUNERAL DIRECTOR: Harvey L. Fleagle — ADDRESS: Hyndman, Pennsylvania

25a. REC'D BY REGISTRAR DATE: MAR 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02990 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02982

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oldtown
d. STREET ADDRESS: Route 1 Box 187
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Phoebe — Last: Robertson

4. DATE OF DEATH: Month: March — Day: 16 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/11/1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Emory Wilson

14. MOTHER'S MAIDEN NAME: Dora Leskia Athey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Theodore R. Robertson — Address: Route 1, Box 187 Oldtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gangrene of Bowel	30 Hours
DUE TO (b)	Mesenteric Thrombosis	30 Hours
DUE TO (c)	Arteriosclerosis	----

4501

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: March 16, 1967

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/19/67

23c. NAME OF CEMETERY OR CREMATORY: Greenridge Cemetery

23d. LOCATION (City, town or county) (State): Near Oldtown Md.

24. FUNERAL DIRECTOR: John J. Hafer, Jr. — ADDRESS: 230 Baltó Ave. Cumberland Md

25a. REC'D BY REGISTRAR DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02991 02983

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 217 Maryland Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 217 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Matilda; Middle: Evelyn; Last: Robinette

4. DATE OF DEATH: Month: March; Day: 19; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10, 1876

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Near Fairview, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fletcher

14. MOTHER'S MAIDEN NAME: Nancy Jane Weimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-16-2647

17. INFORMANT: Mrs. Rhea Bolinger — Address: 217 Maryland Ave Cumberland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Myocarditis — 2 yrs
DUE TO (c): Arteriosclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1965 to Mar 19, 1967 that (I) (we) last saw the deceased alive on May 15 1967, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/20/67

22c. PHYSICIAN'S NAME (Type): Clay E. Durrett

22d. ADDRESS: 236 Va. Ave.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/22/67

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR: John J. Hafer, Jr.

ADDRESS: 230 Baltic Ave, Cumberland, Md.

25a. REC'D BY REGISTRAR: MAR 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02992

CERTIFICATE OF DEATH

02984

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 49 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: W. VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER
d. STREET ADDRESS: ROUTE #3,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CONRAD — Middle J. — Last ROBY
4. DATE OF DEATH: Month MARCH — Day 17 — Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-25-86
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): W. VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: BENJAMIN ROBY
14. MOTHER'S MAIDEN NAME: ELIZABETH POWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic congestive heart — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
DUE TO (b): failure
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last — DUE TO (c): A.S.H. coronary occlusion — 6 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3-2-67, 19__ to 3-17, 19__ that (I) (we) last saw the deceased alive on 19__, and that death occurred at 7:25 AM, from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: MD.
22c. PHYSICIAN'S NAME (Type): DR. WYAND F. DOERNER
22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND,

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 20 Mar 1967
23c. NAME OF CEMETERY OR CREMATORY: Biertown
23d. LOCATION (City or Town) (County) (State): Allegany Co. Md.

24. FUNERAL DIRECTOR: Allen M. Rotruck — ADDRESS: Keyser, W. Va.
25a. REC'D BY REGISTRAR: DATE MAR 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02993

CERTIFICATE OF DEATH

02985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 1 HR.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   d. STREET ADDRESS: 100 PENNA. AVENUE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAKIN — Middle — Last ROOT

4. DATE OF DEATH: Month MARCH — Day 16 — Year 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-28-10

9. AGE (In years last birthday): 56 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INN MANAGER

10b. KIND OF BUSINESS OR INDUSTRY: CIRCLE INN

11. BIRTHPLACE (County & State, or foreign country): PRESTON CO, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM ROOT

14. MOTHER'S MAIDEN NAME: ALICE ~~SAUNAM~~ SHANAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-10-1019

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Unprovoked assault for hire, aortic — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Unprovoked injection — 4½ hrs.
   DUE TO
   (c): Coronary atherosclerosis. — 15 yrs

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia, bilateral infiltrates

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950 to 3/16, 19 67, that (I) (we) last saw the deceased alive on 3/16 19 67, and that death occurred at 12:30P M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/16/67

22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN

22d. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/19/67

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

23d. LOCATION (City or Town) (County) (State): NEAR CUMBERLAND ALLEG MD

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: John J. Hafer, 230 Balto Ave., Cumberland, Md

25a. REC'D BY REGISTRAR — DATE: MAR 20 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02994 02986

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
d. STREET ADDRESS: 186 W. Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: ; Last: Ruffo

4. DATE OF DEATH: Month: March; Day: 24th,; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 25th, 1894

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Operator

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Antonio Ruffo

14. MOTHER'S MAIDEN NAME: Rosina Morro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: 214-32-2802

17. INFORMANT Address: Carl Ruffo, Federal St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured Aorta — INTERVAL BETWEEN ONSET AND DEATH: Minutes

8234

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Crushed Chest — Sudden

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of Car which Crashed into a tree

20c. TIME OF INJURY Hour: 5:00 p.m. Month, Day, Year: March 24 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 12 West Main St.

20f. (City or town) (County) (State): Frostburg, Allegany, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 24, 1967

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-27-67

22c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery

22d. LOCATION (City, town, or county) (State): Frostburg, md.

23. FUNERAL DIRECTOR: Joseph R. Durst, Sr.

ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR: MAR 28 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02995 — 02987

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 8 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 208 CHARLES STREET

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 208 CHARLES STREET
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia; Middle: M; Last: Rydahl

4. DATE OF DEATH: Month: March; Day: 11; Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 24, 1888

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DRESSMAKER

10b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED

11. BIRTHPLACE (State or foreign country): MICHIGAN

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PETER HANSEN

14. MOTHER'S MAIDEN NAME: ANNA JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

16. (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 345 22 8908

17. INFORMANT: LILLIAN YATES,

Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Sclerosis

DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town or county): Cumberland, Maryland

DATE SIGNED: March 11, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MARCH 14, 1967

22c. NAME OF CEMETERY OR CREMATORY: OAK HILL CEMETERY

22d. LOCATION (City, town, or county) (State): GRAND RAPIDS, MICHIGAN

23. FUNERAL DIRECTOR: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

24a. REC'D BY REGISTRAR (DATE): MAR 15 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02996

CERTIFICATE OF DEATH

02988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3MO 12 DA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 49 N. MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALSTON — Middle DAYTON — Last SCHELL
4. DATE OF DEATH: Month MARCH — Day 12 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8. DATE OF BIRTH: 3-24-1895
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: R & O
11. BIRTHPLACE (County & State, or foreign country): MAYSVILLE, W. VA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Z. TAYLOR SCHELL
14. MOTHER'S MAIDEN NAME: SUSAN SEARS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia (terminal) and Congestive — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Heart Failure — 3 da ys
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prostatic Carcinoma with metastases to lungs and skeleton — 8 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 24th, 1966, to March 12, 19 67 that (I) (we) last saw the deceased alive on March 12th, 19 67 and that death occurred at 1:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-14-67
22c. PHYSICIAN'S NAME (Type): WYAND F. DOERNER M.D.
22d. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/15/67
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore Md.
24. FUNERAL DIRECTOR — ADDRESS: Lewis Stein Inc. Cumb. Md
25a. REC'D BY REGISTRAR DATE: MAR 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02989

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cresaptown,
d. STREET ADDRESS: Winchester Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Virginia — Last: Shank
4. DATE OF DEATH: Month: March — Day: 20, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 5, 1882
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Augusta, W. Va.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David Wright
14. MOTHER'S MAIDEN NAME: Elizabeth Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,
16. SOC. SECURITY NO: None
17. INFORMANT — Address: Miss Nina L. Shank Winchester Rd. Cresaptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I — DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS — ----
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.
22. DATE SIGNED: 3/20/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/22/67
23c. NAME OF CEMETERY OR CREMATORY: Indian Mound Cemetery
23d. LOCATION (City or Town) (County) (State): Romney, Hampshire, W. Va.

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Maryland
25a. RECD BY REGISTRAR — DATE: MAR 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
6M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02998

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02990

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: 90 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 605 Virginia Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: T. — Last: Shewbridge

4. DATE OF DEATH: Month: March — Day: 22 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 11, 1875

9. AGE (In years last birthday): 91 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Transfer Co.

11. BIRTHPLACE (State or foreign country): Harpers Ferry, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin C. Shewbridge

14. MOTHER'S MAIDEN NAME: Mary Margaret Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Daughter — Address: Mrs. Anna Mahaney, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Coronary Sclerosis with Thrombosis — --

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lobar Pneumonia, terminal; Chronic Glomerulonephritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from. Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 3-22-1967

Address (Street city, town, or county): Rt.9 Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar.24,1967

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.

25a. RECD BY REGISTRAR: MAR 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02993 02991

1 PLACE OF DEATH
a. COUNTY: Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 229 Baltimore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Cloyd Middle Raymond Last Smith

4 DATE OF DEATH: Month March Day 1 Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 21, 1895

9 AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired employee- B & O

10b. KIND OF BUSINESS OR INDUSTRY: R.R.

11. BIRTHPLACE (State or foreign country): Fairhope Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harvey Smith

14. MOTHER'S MAIDEN NAME: Alice Martz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W W I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Richard H. Smith Address: 119 Weber Street Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Sclerosis — ---
DUE TO
(c):

4401

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Maryland

22. DATE SIGNED: March 1, 1967

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/3/67
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS: H. Lee Silcox Cumberland, Maryland 21502

25a. REC'D BY REGISTRAR DATE: MAR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03000 — 02992

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Sacred Heart Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 144 Polk St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Tyson — Middle: Marion — Last: Smoak
4 DATE OF DEATH: Month: March — Day: 4, — Year: 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: March 19, 1905
9 AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef
10b KIND OF BUSINESS OR INDUSTRY: Restaurant
11 BIRTHPLACE (State or foreign country): Bamberg Co. S. C.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William B. Smoak
14. MOTHER'S MAIDEN NAME: Della Sandifer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO: 248-30-9008
17. INFORMANT — Address: Mr. Jones A. Smoak 608 N. 2nd St. LaVale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion, Left — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Coronary Thrombosis, Left — ---
DUE TO
(c): Coronary Sclerosis — ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left Ventricular Hypertrophy, Marked; Rheumatic Acrtic Stenosis
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: March 4, 1967
Address (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/8/67
23c NAME OF CEMETERY OR CREMATORY: Denmark Cemetery
23d LOCATION (City or Town) (County) (State): Denmark, Bamberg, So. Carolina

24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.
25a REC'D BY REGISTRAR DATE: MAR 7 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03001

CERTIFICATE OF DEATH

02993

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG (MT. SAVAGE)
d. STREET ADDRESS: P.O.BOX 267
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle WILLIAM Last SWEENE
4. DATE OF DEATH: Month MARCH Day 10 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-31-1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COAL MINER
10b. KIND OF BUSINESS OR INDUSTRY: COAL
11. BIRTHPLACE (County & State, or foreign country): MT. SAVAGE, MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM H. SWEENE
14. MOTHER'S MAIDEN NAME: LILLIAN STEVENS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO
16. SOCIAL SECURITY NO: 216-09-9238
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro Vascular Hemorrhage
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) ___
INTERVAL BETWEEN ONSET AND DEATH: 2 hrs. / 10 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/24/67, 19___, to 3/10/67, 19___, that (I) (~~saw~~) last saw the deceased alive on 3/10/67 19___, and that death occurred at 7:25 PM, from causes and on the date stated above.

22a. SIGNATURE: R. J. Williams
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/13/67
22c. PHYSICIAN'S NAME (Type): RICHARD J. WILLIAMS, MD.
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: MARCH 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEM. PARK
23d LOCATION (City or Town) (County) (State): CUMBERLAND, MARYLAND

24 FUNERAL DIRECTOR ADDRESS: MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60W. MAIN, FROSTBURG
25a. REC'D BY REGISTRAR DATE: MAR 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge
Marilou M. Sowers

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03002

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02994

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 58 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 Spruce

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport,
d. STREET ADDRESS: 211 Spruce
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle William Last Taylor

4. DATE OF DEATH: Month Mar. Day 30 Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 22, 1908

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Taylor

14. MOTHER'S MAIDEN NAME: Mary Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: John J. Taylor Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosos
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
OEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: 3/31/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/2/67
23c. NAME OF CEMETERY OR CREMATORY: Walden
23d. LOCATION (City, town or county) (State): Westernport Md.

24. FUNERAL DIRECTOR: E. F. Bird ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03003 02995

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE
d. STREET ADDRESS: RT. #2, BOX 11
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: BABY GIRL (A) Middle: Last: TICE

4 DATE OF DEATH: Month: 3 Day: 12 Year: 19 67

5 SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-11-67

9 AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 20 Min.: 15

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country): MEYERSDALE, PA.

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: LEWIS J. TICE

14. MOTHER'S MAIDEN NAME: ESTHER YODER

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 19 hrs.
DUE TO
(b): Prematurity
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from _____, 19___ to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 5:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert D Brodell M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. ROBERT BRODELL

22d. ADDRESS: GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/13/67

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Amish-Menn.

23d LOCATION (City or Town) (County) (State): West Salisbury, Somerset,

24. FUNERAL DIRECTOR: Ruth E. Neuvent — **ADDRESS**: Jennerville, Pa.

25a. REC'D BY REGISTRAR: MAR 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03004

CERTIFICATE OF DEATH

02996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE
d. STREET ADDRESS: 57 LAVALE COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ALBERT	F. T.	TOMSKO	MARCH	4	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white		1-9-07	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retail Merchant - Self	Employed	Johnstown, Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Tobias Tomsko	Katherine(Thomay Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	217-10-6675	Patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Right Heart Failure	1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cor pulmonale	3 mos
DUE TO (c)	Emphysema	10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteoporosis, kyphoscoliosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-15, 1959, to 3-4, 1967, that (I) (we) last saw the deceased alive on 3-4 1967, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Ralph W. Ballin					3-6-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Ralph W. Ballin, M.D.	62 Greene St., Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3/7/67	Hillcrest Burial Park	Cumberland Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Lee Silcox	Cumberland Maryland 21502	MAR 7 1967	[illegible]

VR A15 (4)
2DM 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03005 02997

1. PLACE OF DEATH
a. COUNTY: ALLEGany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE
d. STREET ADDRESS: ROUTE # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ICIE	PEARL	TRAIL	MARCH	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE	MARRIED [X]	3-7-09	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		WEST VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM WEAVER	ZELLA (DOLLY) [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		PT'S CHAR. George H Trail	Route 1 Flintstone Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial failure	18 days
4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Infarction	18 days
DUE TO (c)	Coronary artery disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO [X]

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 19 67 to March 19, 19 67 that (I) (we) last saw the deceased alive on March 19, 19 67, and that death occurred at 6.25 PM, from the causes and on the date stated above.

22a. SIGNATURE: James P. Hallinan M.D. — M.D. ATTENDING PHYS. [X] MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3-20-67

22c. PHYSICIAN'S NAME (Type): James P. Hallinan M. D. DR. HALLINAN — 22d. ADDRESS: 140 BEDFORD ST CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3/22/67	Hillcrest Burial Park	Near Cumberland, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr., 230 Balto Ave., Cumberland, Md	MAR 23 1967	J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02998

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt#1 Near Paw Paw,W.Va
c LENGTH OF STAY IN 1b: 25yrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt# 1 Near Paw Paw,W.Va

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt#1 Near Paw Paw,W.Va.
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First James — Middle — Last Twigg

4 DATE OF DEATH: Month March — Day 4, — Year 19 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: March 13, 1900

9 AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Amanda Twigg

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17 INFORMANT: Address: Cousin
Mrs. Hubbard Twigg, Cumberland,Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Coronary Thrombosis — --
DUE TO
(c): Coronary Sclerosis — --

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity, Marked

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour, a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Cumberland, Md.

22. DATE SIGNED: March 4, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: March 7,1967

23c NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d LOCATION (City or Town) (County) (State): Cumberland,Maryland

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli Cumberland,Maryland

25a RECD BY REGISTRAR DATE: MAR 7 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03007

CERTIFICATE OF DEATH

02999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
   c. LENGTH OF STAY IN 1b: LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL[1]

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
   d. STREET ADDRESS: 228 N. Lee St. [redacted]
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CATHERINE Middle Elizabeth Last WAHL

4. DATE OF DEATH: Month 03 Day 28 Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 03-29-1879

9. AGE (In years last birthday): 87 yrs.
   IF UNDER 1 YEAR: Months | Days
   IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (County & State, or foreign country): ALLEGANY COUNTY, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis [illegible] WAHL

14. MOTHER'S MAIDEN NAME: MARY E. (BURKHart (

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-9507

17. INFORMANT: SACRED HEART HOSPITAL Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE AND ARTERIOSCLEROTIC CVD — YEARS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASTHMATIC BRONCHITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-17- 19 67 to 3-28- 19 67 that (I) (we) last saw the deceased alive on 3-28- 19 67 and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. Wayne Doerner Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-28-67

22c. PHYSICIAN'S NAME (Type): WYAND F. DOERNER, JR., M.D.

22d. ADDRESS: 414 N. MECHANIC STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/31/67

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.

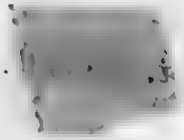
23d. LOCATION (City, town or county) (State): Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS: H. Wayne George Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03008

CERTIFICATE OF DEATH

03000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2 ■ 1/66

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 282 East Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Floyd — Middle: Dayton — Last: Walters

4. DATE OF DEATH: Month: March — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 17, 1894

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Walters

14. MOTHER'S MAIDEN NAME: Amanda King

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-5952

17. INFORMANT: Mrs. Edna E. Walters — Address: 282 E. Main St Frostburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerosis - generalized — years
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Recent CVA — Ca of large bowel

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar. 12, 1967, to Mar. 18, 1967, that (I) (we) last saw the deceased alive on Mar. 18 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: L.R. Miles Jr MD — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-21-67

22c. PHYSICIAN'S NAME (Type): L.R. MILES JR MD

22d. ADDRESS: LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/21/67

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City or Town) (County) (State): Frostburg Alleg Md

24. FUNERAL DIRECTOR: John J. Hafer, Jr.

ADDRESS: John J. Hafer, Jr. 930 Balto Ave Cumberland, Md

25a. REC'D BY REGISTRAR: MAR 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03001

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c LENGTH OF STAY IN 1b: 45yrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 33 Fifth Street

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d STREET ADDRESS: 17 Humbird Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Clyde — Middle: — Last: White

4 DATE OF DEATH: Month: March — Day: 8, — Year: 1967

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: June 16, 1907

9 AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b KIND OF BUSINESS OR INDUSTRY: Different Types

11 BIRTHPLACE (State or foreign country): Davis W.Va.

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: John White

14 MOTHER'S MAIDEN NAME: Frances Wolford

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): War 11

16 SOCIAL SECURITY NO: 214-05-6060

17 INFORMANT: Address: Mrs. Thelma Nines, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion, left — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Thrombosis, left — --

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Coronary Sclerosis — --

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac Hypertrophy, left; Pulmonary Emphysema

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 3-8-1967

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Rt.9 Cumberland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: March 12,1967

23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany

24 FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.

ADDRESS

25a REC'D BY REGISTRAR: MAR 14 1967

25b REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03002

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, 01-1
d. STREET ADDRESS: 207 Greene St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Sterling — Last: Wood

4. DATE OF DEATH: Month: March — Day: 29, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/25/06

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Textile Plant

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Morgan Wood

14. MOTHER'S MAIDEN NAME: Margaret L. Kaden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,

16. SOCIAL SECURITY NO.: 214-07-4898

17. INFORMANT — Address: Miss Betty Wood 207 Greene St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra-abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 45 mins.
DUE TO (b): Rupture of arteriosclerotic Aortic Aneurysm — 45 mins.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Rt. # 9 Balto. Pike Cumb. Md.

22. DATE SIGNED: 3/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/1/67
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03011

03003

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 901 YALE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle W. — Last ZAIS
4. DATE OF DEATH: Month MARCH — Day 1 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-23-05
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WESTERNPORT, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN ZAIS
14. MOTHER'S MAIDEN NAME: MAE PATRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-07-1103
17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Failure due
DUE TO (b): To Chronic Myocarditis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 15 1967 to 3/1/67, 19__ that (I) (we) last saw the deceased alive on 2/20/67 19__, and that death occurred at 8:05A M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/3/67
22c. PHYSICIAN'S NAME (Type): DR. R.J. WILLIAMS
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/3/67
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR — ADDRESS: H. Lee Silcox Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE: MAR 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66